Our Lady of Mercy N.S., Bantry, Co. Cork

ADMINISTRATION OF MEDICINES/MONITORING OF MEDICAL CONDITION

CHILD'S NAME: _____
ADDRESS: _____
DATE OF BIRTH: _____

EMERGENCY CONTACTS:

1) NAME: _____ **PHONE:** _____
2) NAME: _____ **PHONE:** _____
3) NAME: _____ **PHONE:** _____
4) NAME: _____ **PHONE:** _____
CHILD'S DOCTOR: _____ **PHONE:** _____

DIAGNOSED CONDITIONS:

_____
_____

PRESCRIPTION DETAILS:

Medication	Dose	Frequency

Is the child to be responsible for taking the prescription him/herself? _____

I/We request that the Board of Management authorise the taking of Prescription Medicine during the school day as it is absolutely necessary for the continued well being of my/our child. I/We understand that the school has no facilities for the safe storage of prescription medicines and that the prescribed amounts be brought in daily. I/We understand that we must inform the school/Teacher of any changes of medicine/dose in writing and that we must inform the Teacher each year of the prescription/medical condition. I/We understand that no school personnel have any medical training and we indemnify the Board from any liability that may arise from the administration of the medication.

SIGNED: _____ Parent/Guardian
_____ Parent/Guardian

DATE: _____